		FOR OHF USE					

LL1

2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0042119

Facility Name: South Shore Nsg & Rehab Ctr

Address: 2649 E. 75Th Street (Number) Chicago (City) 60649 (Zip Code)

County: Cook

Telephone Number: (773) 356-9300 **Fax #** (773) 356-9384

IDPA ID Number: 364209295001

Date of Initial License for Current Owners: 05/28/98

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/04 to 12/31/04 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) Edward N. Slack, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/04 Ending: 12/31/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	240	Skilled (SNF)	240	87,840	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	240	TOTALS	240	87,840	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	64,861	4,416	9,297	78,574	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	64,861	4,416	9,297	78,574	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.45%

D. How many bed-hold days during this year were paid by Public Aid?
199 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 5/28/98

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 5/28/98 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 240 and days of care provided 9,193

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/04 Fiscal Year: 12/31/04

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	330,183	42,535	19,814	392,532		392,532	(10,273)	382,259			1
2	Food Purchase		288,629		288,629	(7,774)	280,855	5,343	286,199			2
3	Housekeeping	237,011	63,444		300,455		300,455	(8,918)	291,537			3
4	Laundry	111,372	32,034	2,278	145,684		145,684	(130)	145,554			4
5	Heat and Other Utilities			292,548	292,548		292,548	1,964	294,512			5
6	Maintenance	83,370		259,051	342,421		342,421	2,736	345,157			6
7	Other (specify):*							5,878	5,878			7
8	**TOTAL General Services**	761,936	426,642	573,691	1,762,269	(7,774)	1,754,495	(3,400)	1,751,095			8
	B. Health Care and Programs											
9	Medical Director			9,750	9,750		9,750		9,750			9
10	Nursing and Medical Records	2,927,971	53,857	17,653	2,999,481		2,999,481	16,813	3,016,294			10
10a	Therapy	96,370			96,370		96,370		96,370			10a
11	Activities	164,956	8,492	952	174,400		174,400	(168)	174,232			11
12	Social Services	167,618		5,721	173,339		173,339	14,125	187,464			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*							7,554	7,554			15
16	**TOTAL Health Care and Programs**	3,356,915	62,349	34,076	3,453,340		3,453,340	38,324	3,491,664			16
	C. General Administration											
17	Administrative	97,853		45,713	143,566		143,566	(5,922)	137,644			17
18	Directors Fees											18
19	Professional Services			405,506	405,506	(15,538)	389,968	(321,796)	68,172			19
20	Dues, Fees, Subscriptions & Promotions			60,914	60,914		60,914	(32,585)	28,329			20
21	Clerical & General Office Expenses	100,094	17,225	477,481	594,800		594,800	(208,111)	386,689			21
22	Employee Benefits & Payroll Taxes			791,867	791,867	7,774	799,641	(13,889)	785,752			22
23	Inservice Training & Education			625	625		625		625			23
24	Travel and Seminar			2,716	2,716		2,716	5,319	8,035			24
25	Other Admin. Staff Transportation			417	417		417		417			25
26	Insurance-Prop.Liab.Malpractice			245,316	245,316		245,316	1,156	246,472			26
27	Other (specify):*							32,044	32,044			27
28	**TOTAL General Administration**	197,947	17,225	2,030,555	2,245,727	(7,764)	2,237,963	(543,784)	1,694,179			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,316,798	506,216	2,638,322	7,461,336	(15,538)	7,445,798	(508,859)	6,936,938			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number South Shore Nsg & Rehab Ctr #0042119 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			75,095	75,095		75,095	440,913	516,008			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			79	79		79	471,679	471,758			32
33	Real Estate Taxes			321,460	321,460	15,538	336,998	2,426	339,424			33
34	Rent-Facility & Grounds			1,357,800	1,357,800		1,357,800	(1,351,176)	6,624			34
35	Rent-Equipment & Vehicles			7,534	7,534		7,534	2,366	9,900			35
36	Other (specify):*							24,049	24,049			36
37	**TOTAL Ownership**			1,761,968	1,761,968	15,538	1,777,506	(409,743)	1,367,763			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		452,699	597,432	1,050,131		1,050,131	(19,684)	1,030,447			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			131,760	131,760		131,760		131,760			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		452,699	729,192	1,181,891		1,181,891	(19,684)	1,162,207			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,316,798	958,915	5,129,482	10,405,195		10,405,195	(938,286)	9,466,909			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/04 Ending: 12/31/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	124,738	30		9
10	Interest and Other Investment Income	(450,004)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(160)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(517)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(218,650)	21		24
25	Fund Raising, Advertising and Promotional	(5,064)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(9,950)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(213,215)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (772,822)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(165,464)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (165,464)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (938,286)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

South Shore Nsg & Rehab Ctr

ID# 0042119

Report Period Beginning: 01/01/04

Ending: 12/31/04

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Jury Duty Income	$ (34)	10	1
2	Patient Clothing	(160)	10	2
3	Capitalized R&M	(6,111)	06	3
4	Theft Loss	(162)	21	4
5	Collection	(243)	21	5
6	Discounts	(1,841)	21	6
7	Prior Year Medical Record Consultant cost	(1,022)	10	7
8	Accrued Legal Fees	5,401	19	8
9	Management Fees - Ronald Abrams	(12,000)	17	9
10	Management Fees - Alan Abrams	(12,000)	17	10
11	COPE Dues	(2,926)	20	11
12	Civil Money Penalty	(5,850)	20	12
13	Building Co. - Trust Fees	(525)	20	13
14	Building Co. - Filing Fees	(250)	20	14
15	PPA - Service Contract	(238)	06	15
16	PPA - Activity Consultant	(168)	11	16
17	Diawa Legal Fee	(80)	19	17
18	Non-allowable Legal Fees	(1,716)	19	18
19	Personal Property Use Tax	(3,003)	22	19
20	Non-Allowable Expense	(170,287)	21	20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
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96				96
97				97
98				98
99				99
100				100
101	Total	(213,215)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/04 Ending: 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary				(99)	515		(4,071)	(6,618)				(10,273)	1
2	Food Purchase	(160)			(23)				5,527				5,343	2
3	Housekeeping				(8,918)								(8,918)	3
4	Laundry				(130)								(130)	4
5	Heat and Other Utilities					1,964							1,964	5
6	Maintenance	(6,349)			(43)	2,097		6,995	36				2,736	6
7	Other (specify):*						3,676	1,709	493				5,878	7
8	**TOTAL General Services**	(6,509)			(9,213)	4,576	3,676	4,633	(562)				(3,400)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(1,216)			(6,417)			24,446					16,813	10
10a	Therapy													10a
11	Activities	(168)											(168)	11
12	Social Services							14,125					14,125	12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*						1,911	5,643					7,554	15
16	**TOTAL Health Care and Programs**	(1,384)			(6,417)		1,911	44,214					38,324	16
	C. General Administration													
17	Administrative	(24,000)						17,837	241				(5,922)	17
18	Directors Fees													18
19	Professional Services	3,605				(325,426)			25				(321,796)	19
20	Fees, Subscriptions & Promotions	(15,132)	775			(18,241)			13				(32,585)	20
21	Clerical & General Office Expenses	(401,133)			(76)	19,155		173,508	435				(208,111)	21
22	Employee Benefits & Payroll Taxes	(3,003)		(603)	(165)		(10,118)						(13,889)	22
23	Inservice Training & Education													23
24	Travel and Seminar					5,211			108				5,319	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice					1,063			93				1,156	26
27	Other (specify):*						4,281	27,763					32,044	27
28	**TOTAL General Administration**	(439,663)	775	(603)	(241)	(318,238)	(5,837)	219,108	915				(543,784)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(447,556)	775	(603)	(15,871)	(313,662)	(250)	267,955	353				(508,859)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	124,738	296,595			19,471				109			440,913	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(450,004)	921,657						14	12			471,679	32
33	Real Estate Taxes					2,426							2,426	33
34	Rent-Facility & Grounds		(1,357,800)			6,123			501				(1,351,176)	34
35	Rent-Equipment & Vehicles					2,355			11				2,366	35
36	Other (specify):*		24,049										24,049	36
37	**TOTAL Ownership**	(325,266)	(115,499)			30,375			526	121			(409,743)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers				(14,231)				(5,228)	(225)			(19,684)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**				(14,231)				(5,228)	(225)			(19,684)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(772,822)	(114,724)	(603)	(30,102)	(283,287)	(250)	267,955	(4,349)	(104)			(938,286)	45

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		
				South Shore Properties, LLC		Building Company

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 1,357,800	South Shore Properties, LLC		$	$ (1,357,800)	1
2	V	20	Trust Fees		South Shore Properties, LLC		525	525	2
3	V	20	Filing Fees		South Shore Properties, LLC		250	250	3
4	V	30	Depreciation		South Shore Properties, LLC		296,595	296,595	4
5	V	36	Amortization		South Shore Properties, LLC		24,049	24,049	5
6	V	32	Interest		South Shore Properties, LLC		921,657	921,657	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,357,800			$ 1,243,076	$ * (114,724)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V		22	EMPLOYEE HEALTH INSURANCE	$	CCS EMPLOYEE BENEFIT GROUP	100.00%	$ 111,093	$ 111,093	15
16	V									16
17	V									17
18	V									18
19	V		22	EMPLOYEE HEALTH INSURANCE	111,696	CCS EMPLOYEE BENEFIT GROUP	100.00%		(111,696)	19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$ 111,696			$ 111,093	$ * (603)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	DIETARY	$ 667	XCEL MEDICAL SUPPLY, LLC	100.00%	$ 568	$ (99)	15
16	V	02	FOOD	156	XCEL MEDICAL SUPPLY, LLC	100.00%	133	(23)	16
17	V	03	HOUSEKEEPING	60,113	XCEL MEDICAL SUPPLY, LLC	100.00%	51,194	(8,918)	17
18	V	04	LAUNDRY	877	XCEL MEDICAL SUPPLY, LLC	100.00%	747	(130)	18
19	V	06	REPAIRS & MAINTENANCE	288	XCEL MEDICAL SUPPLY, LLC	100.00%	245	(43)	19
20	V	10	NURSING	43,251	XCEL MEDICAL SUPPLY, LLC	100.00%	36,834	(6,417)	20
21	V	10A	THERAPY		XCEL MEDICAL SUPPLY, LLC	100.00%			21
22	V	12	SOCIAL SERVICE		XCEL MEDICAL SUPPLY, LLC	100.00%			22
23	V	21	CLERICAL & GENERAL OFFICE	513	XCEL MEDICAL SUPPLY, LLC	100.00%	437	(76)	23
24	V	22	EMPLOYEE BENEFITS	1,111	XCEL MEDICAL SUPPLY, LLC	100.00%	946	(165)	24
25	V	39	ANCILLARY	95,920	XCEL MEDICAL SUPPLY, LLC	100.00%	81,689	(14,231)	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 202,896			$ 172,794	$ * (30,102)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary	$	Care Centers, Inc.	100.00%	$ 515	$ 515	15
16	V	05	Utilities		Care Centers, Inc.	100.00%	1,964	1,964	16
17	V	06	Maintenance		Care Centers, Inc.	100.00%	2,097	2,097	17
18	V	10	Nursing		Care Centers, Inc.	100.00%			18
19	V	11	Activities		Care Centers, Inc.	100.00%			19
20	V	19	Professional Fees	336,000	Care Centers, Inc.	100.00%	10,574	(325,426)	20
21	V	20	Dues and Subscriptions	21,900	Care Centers, Inc.	100.00%	3,659	(18,241)	21
22	V	21	Office & Clerical		Care Centers, Inc.	100.00%	19,155	19,155	22
23	V	24	Travel and Seminar		Care Centers, Inc.	100.00%	5,211	5,211	23
24	V	26	Insurance		Care Centers, Inc.	100.00%	1,063	1,063	24
25	V	30	Depreciation		Care Centers, Inc.	100.00%	19,471	19,471	25
26	V	32	Interest		Care Centers, Inc.	100.00%			26
27	V	33	Real Estate Taxes		Care Centers, Inc.	100.00%	2,426	2,426	27
28	V	34	Rent - Building		Care Centers, Inc.	100.00%	6,123	6,123	28
29	V	35	Rent - Equipment and Auto		Care Centers, Inc.	100.00%	2,355	2,355	29
30	V	25	Bus Reimbursement		Care Centers, Inc.	100.00%			30
31	V	02	Food		Care Centers, Inc.	100.00%			31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 357,900			$ 74,613	$ * (283,287)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	06	Maintenance Salary	$ 25,125	Care Centers, Inc.	100.00%	$ 25,125	$	15
16	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	3,676	3,676	16
17	V	10	Nursing Salary	9,530	Care Centers, Inc.	100.00%	9,530		17
18	V	10a	Rehab Salary		Care Centers, Inc.	100.00%			18
19	V	11	Activity Salary		Care Centers, Inc.	100.00%			19
20	V	12	Social Service Salary	3,534	Care Centers, Inc.	100.00%	3,534		20
21	V	15	Emp. Ben. - Healthcare		Care Centers, Inc.	100.00%	1,911	1,911	21
22	V	17	Administration Salary		Care Centers, Inc.	100.00%			22
23	V	21	Office Salary	29,262	Care Centers, Inc.	100.00%	29,262		23
24	V	27	Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	4,281	4,281	24
25	V	22	Employee Benefits	10,118	Care Centers, Inc.	100.00%		(10,118)	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 77,569			$ 77,319	$ * (250)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary Salary	$ 8,760	Care Centers, Inc.	100.00%	$ 4,689	$ (4,071)	15
16	V	03	Housekeeping Salary		Care Centers, Inc.	100.00%			16
17	V	06	Maintenance Salary		Care Centers, Inc.	100.00%	6,995	6,995	17
18	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	1,709	1,709	18
19	V	10	Nursing Salary		Care Centers, Inc.	100.00%	24,446	24,446	19
20	V	10a	Rehab Salary		Care Centers, Inc.	100.00%			20
21	V	12	Social Services Salary		Care Centers, Inc.	100.00%	14,125	14,125	21
22	V	15	Emp. Ben. - Healthcare		Care Centers, Inc.	100.00%	5,643	5,643	22
23	V	17	Administration Salary		Care Centers, Inc.	100.00%	17,837	17,837	23
24	V	21	Office Salary		Care Centers, Inc.	100.00%	173,508	173,508	24
25	V	27	Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	27,763	27,763	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 8,760			$ 276,715	$ * 267,955	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary	$ 10,919	Care Centers, Inc. - Health Systems Division	100.00%	$ 934	$ (9,985)	15
16	V	02	Food		Care Centers, Inc. - Health Systems Division	100.00%	5,527	5,527	16
17	V	06	Maintenance		Care Centers, Inc. - Health Systems Division	100.00%	36	36	17
18	V	17	Administration		Care Centers, Inc. - Health Systems Division	100.00%	241	241	18
19	V	19	Professional Fees		Care Centers, Inc. - Health Systems Division	100.00%	25	25	19
20	V	20	Dues & Subscriptions		Care Centers, Inc. - Health Systems Division	100.00%	13	13	20
21	V	21	Office & Clerical		Care Centers, Inc. - Health Systems Division	100.00%	435	435	21
22	V	24	Travel & Seminar		Care Centers, Inc. - Health Systems Division	100.00%	108	108	22
23	V	26	Insurance		Care Centers, Inc. - Health Systems Division	100.00%	93	93	23
24	V	32	Interest Expense		Care Centers, Inc. - Health Systems Division	100.00%	14	14	24
25	V	34	Rent - Building		Care Centers, Inc. - Health Systems Division	100.00%	501	501	25
26	V	35	Rent - Equipment & Auto		Care Centers, Inc. - Health Systems Division	100.00%	11	11	26
27	V	39	Ancillary Enteral Supplies	10,587	Care Centers, Inc. - Health Systems Division	100.00%	5,359	(5,228)	27
28	V	01	Dietary - Salary		Care Centers, Inc. - Health Systems Division	100.00%	3,367	3,367	28
29	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc. - Health Systems Division	100.00%	493	493	29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 21,506			$ 17,157	$ * (4,349)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V		30	Depreciation	$	Vent Lease, LLC.	100.00%	$ 109	$ 109	15
16	V		32	Interest		Vent Lease, LLC.	100.00%	12	12	16
17	V		39	Vent Reimbursement	225	Vent Lease, LLC.	100.00%		(225)	17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$ 225			$ 121	$ * (104)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	David Aronin	Owner	Administrative	0.83%	See Attached	2.08	3.71%	Alloc Salary	$ 4,777	17-7	1
2	Sandy Bokor	Relative	Administrative		See Attached	1.00	2.00%	Mgmt Fees	12,000	17-3	2
3	Mark Steinberg	Relative	Administrative		See Attached	5.00	9.09%	Alloc Salary	3,200	17-7	3
4	Eric Rothner	Relative	Administrative		See Attached	1.65	3.58%	Mgmt Fees	9,713	17-3	4
5	Adam Vales	Owner	Clerical	1.88%	See Attached	0.72	1.80%	Alloc Salary	749	22-7	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 30,439		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CCS EMPLOYEE BENEFITS GROUP, INC.
Street Address: 2201 W. MAIN ST.
City / State / Zip Code: EVANSTON, IL 60202
Phone Number: (847)905-4000
Fax Number: (847)905-4040

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	EMPLOYEE HEALTH INSURA	DIRECT ALLOCATION			$	$		$ 111,093	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 111,093	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: XCEL MEDICAL SUPPLY, LLC
Street Address: 2201 MAIN STREET
City / State / Zip Code: EVANSTON, IL 60202
Phone Number: (847)328-7600
Fax Number: (847)328-7615

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	DIETARY	Direct Allocation			$	$		$ 568	1
2	02	FOOD	Direct Allocation						133	2
3	03	HOUSEKEEPING	Direct Allocation						51,194	3
4	04	LAUNDRY	Direct Allocation						747	4
5	06	REPAIRS & MAINTENANCE	Direct Allocation						245	5
6	10	NURSING	Direct Allocation						36,834	6
7	10A	THERAPY	Direct Allocation							7
8	12	SOCIAL SERVICE	Direct Allocation							8
9	21	CLERICAL & GENERAL OFFIC	Direct Allocation						437	9
10	22	EMPLOYEE BENEFITS	Direct Allocation						946	10
11	39	ANCILLARY	Direct Allocation						81,689	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 172,794	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary	Patient Days	1,484,397	42	$ 9,730	$	78,574	$ 515	1
2	05	Utilities	Patient Days	1,484,397	42	37,103		78,574	1,964	2
3	06	Maintenance	Patient Days	1,484,397	42	39,622		78,574	2,097	3
4	10	Nursing	Patient Days	1,484,397	42			78,574		4
5	11	Activities	Patient Days	1,484,397	42			78,574		5
6	19	Professional Fees	Patient Days	1,484,397	42	199,755		78,574	10,574	6
7	20	Dues and Subscriptions	Patient Days	1,484,397	42	69,116		78,574	3,659	7
8	21	Office & Clerical	Patient Days	1,484,397	42	361,868		78,574	19,155	8
9	24	Travel and Seminar	Patient Days	1,484,397	42	98,454		78,574	5,211	9
10	26	Insurance	Patient Days	1,484,397	42	20,081		78,574	1,063	10
11	30	Depreciation	Patient Days	1,484,397	42	367,842		78,574	19,471	11
12	32	Interest	Patient Days	1,484,397	42			78,574		12
13	33	Real Estate Taxes	Patient Days	1,484,397	42	45,838		78,574	2,426	13
14	34	Rent - Building	Patient Days	1,484,397	42	115,677		78,574	6,123	14
15	35	Rent - Equipment & Auto	Patient Days	1,484,397	42	44,486		78,574	2,355	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,409,572	$		$ 74,613	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	06	Maintenance Salary	Direct Cost			264,919	264,919		25,125	1
2	07	Emp. Ben. - Gen. Serv.	Direct Cost			38,757			3,676	2
3	10	Nursing Salary	Direct Cost			209,584	209,584		9,530	3
4	10a	Rehab Salary	Direct Cost			66,982	66,982			4
5	11	Activity Salary	Direct Cost							5
6	12	Social Service Salary	Direct Cost			66,710	66,710		3,534	6
7	15	Emp. Ben. - Healthcare	Direct Cost			50,220			1,911	7
8	17	Administration Salary	Direct Cost			38,431	38,431			8
9	21	Office Salary	Direct Cost			525,935	525,935		29,262	9
10	27	Emp. Ben. - Gen. Admin.	Direct Cost			82,566			4,281	10
11	22	Employee Benefits								11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,344,103	$ 1,172,560		$ 77,319	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary Salary	Patient Days	1,484,397	42	88,579	88,579	78,574	$ 4,689	1
2	03	Housekeeping Salary	Patient Days	1,484,397	42			78,574		2
3	06	Maintenance Salary	Patient Days	1,484,397	42	132,146	132,146	78,574	6,995	3
4	07	Emp. Ben. - Gen. Serv.	Patient Days	1,484,397	42	32,292		78,574	1,709	4
5	10	Nursing Salary	Patient Days	1,484,397	42	461,827	461,827	78,574	24,446	5
6	10a	Rehab Salary	Patient Days	1,484,397	42			78,574		6
7	12	Social Services Salary	Patient Days	1,484,397	42	266,840	266,840	78,574	14,125	7
8	15	Emp. Ben. - Healthcare	Patient Days	1,484,397	42	106,602		78,574	5,643	8
9	17	Administration Salary	Patient Days	1,484,397	42	336,976	336,976	78,574	17,837	9
10	21	Office Salary	Patient Days	1,484,397	42	3,277,864	3,277,864	78,574	173,508	10
11	27	Emp. Ben. - Gen. Admin.	Patient Days	1,484,397	42	524,485		78,574	27,763	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 5,227,610	$ 4,564,232		$ 276,715	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary	Billable Income	2,144,835		93,149		21,506	934	1
2	02	Food	Billable Income	2,144,835		987,169		21,506	5,527	2
3	06	Maintenance	Billable Income	2,144,835		3,597		21,506	36	3
4	17	Administration	Billable Income	2,144,835		24,000		21,506	241	4
5	19	Professional Fees	Billable Income	2,144,835		2,500		21,506	25	5
6	20	Dues & Subscriptions	Billable Income	2,144,835		1,342		21,506	13	6
7	21	Office & Clerical	Billable Income	2,144,835		43,384		21,506	435	7
8	24	Travel & Seminar	Billable Income	2,144,835		10,755		21,506	108	8
9	26	Insurance	Billable Income	2,144,835		9,262		21,506	93	9
10	32	Interest Expense	Billable Income	2,144,835		1,371		21,506	14	10
11	34	Rent - Building	Billable Income	2,144,835		50,000		21,506	501	11
12	35	Rent - Equipment & Auto	Billable Income	2,144,835		1,080		21,506	11	12
13	39	Ancillary Enteral Supplies	Billable Income	2,144,835		98,519		21,506	5,359	13
14	01	Dietary - Salary	Billable Income	2,144,835		335,801	335,801	21,506	3,367	14
15	07	Emp. Ben. - Gen. Serv.	Billable Income	2,144,835		49,127		21,506	493	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,711,055	$ 335,801		$ 17,157	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Vent Lease, LLC
Street Address: 2201 W. Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 674-1180
Fax Number: (847) 673-7741

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	30	Depreciation	Direct Billing	620,670	29	$ 300,000	$	225	$ 109	1
2	32	Interest	Direct Billing	620,670	29	33,493		225	12	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 333,493	$		$ 121	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Corus Bank		X	Mortgage - Building Co.			$	$ 9,210,888			$ 712,178	1
2	CIB Bank		X	Mortgage - Building Co.							106,931	2
3	Amcore Bank		X	Mortgage - Building Co.				3,217,503			88,099	3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	Allocation from Care Centers		X								14	6
7	Allocation from Vent Lease		X								12	7
8	See Supplemental Schedule											8
9	TOTAL Facility Related						$	$ 12,428,391			$ 907,234	9
	B. Non-Facility Related*											
10	Interest Income										(450,004)	10
11												11
12												12
13	See Supplemental Schedule										14,528	13
14	TOTAL Non-Facility Related						$	$			$ (435,476)	14
15	TOTALS (line 9+line14)						$	$ 12,428,391			$ 471,758	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line #

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

SEE ACCOUNTANTS' COMPILATION REPORT

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8							$	$			$	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital											14
	B. Non-Facility Related*											
15	South Shore Nursing Home						$	$			$ 14,449	15
16	(offset with interest income)											16
17	Trust Fund Interest										79	17
18												18
19												19
20	TOTAL Non-Facility Related										14,528	20

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2003 report.	$ 350,813	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$ 330,364	2
3. Under or (over) accrual (line 2 minus line 1).	$ (20,449)	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)	$ 344,335	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$ 15,538	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$ 339,424	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1999	266,137	8
2000	324,625	9
2001	332,159	10
2002	334,103	11
2003	327,938	12

2004 Real Estate Tax = 2003 Expense $327,938 x 1.05 = $344,335

Allocation from Care Centers $2426

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME South Shore Nsg & Rehab Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0042119

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	21-30-200-001-0000	Long Term Care Property	$ 270,997.01	$ 270,997.01
2.	21-30-200-008-0000	Long Term Care Property	$ 50,550.19	$ 50,550.19
3.	21-30-200-002-0000	Long Term Care Property	$ 3,158.60	$ 3,158.60
4.	21-30-121-008-0000	Long Term Care Property	$ 1,483.00	$ 1,483.00
5.	21-30-121-009-0000	Long Term Care Property	$ 1,748.88	$ 1,748.88
6.	See Attached	Home Office Allocation	$ 106,873.39	$ 2,426.00
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 434,811.07	$ 330,363.68

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME South Shore Nsg & Rehab Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0042119

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/04 Ending: 12/31/04

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 96,000 B. General Construction Type: Exterior Brick Frame Steel & Masonry Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	101,000	1994	$ 352,000	1
2	Alloc 2201 Main LLC			18,617	2
3	TOTALS	101,000		$ 370,617	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1998	22,697		20	1,135	1,135	7,160	9
10	Various			1999	22,789		20	1,140	1,140	6,016	10
11	Various			2000	41,526		20	2,076	2,076	9,959	11
12								-		-	12
13								-		-	13
14								-		-	14
15								-		-	15
16								-		-	16
17								-		-	17
18								-		-	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
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59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12-BLDG & 12A-BLDG)		11,725,819	260,958		335,240	74,282	2,168,153	67
68	Related Party Allocations (Pages 12-REP & 12A-REP)		71,822	2,950		2,950		6,125	68
69	Financial Statement Depreciation			32,250			(32,250)		69
70	TOTAL (lines 4 thru 69)		$ 11,884,653	$ 296,158		$ 342,541	$ 46,383	$ 2,197,413	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 11,884,653	$ 296,158		$ 342,541	$ 46,383	$ 2,197,413	1
2	Hot Water Heater	2001	3,980		20	199	199	796	2
3	Fan Power Box	2001	589		20	29	29	115	3
4	Exit Sign	2001	2,336		20	117	117	438	4
5	Chiller Bundle	2001	2,020		20	101	101	370	5
6	Sprinkler System	2001	1,405		20	70	70	252	6
7	Cyllander Assy	2001	2,394		20	120	120	409	7
8	Bypass On Water Heat	2001	2,146		20	107	107	358	8
9	Boiler	2001	4,000		20	200	200	650	9
10	Tube Sections	2001	6,074		20	304	304	987	10
11	Boiler Repair	2001	3,340		20	167	167	529	11
12	Boiler	2001	851		20	43	43	135	12
13	Boiler Repair	2001	10,192		20	510	510	1,614	13
14	Power Wc Repair	2001	575		20	29	29	91	14
15	Tiles	2001	1,550		20	78	78	311	15
16	Boiler Repair	2001	1,676		20	84	84	286	16
17	Motor	2002	582		20	58	58	165	17
18	Water Treatment	2002	1,692		20	141	141	400	18
19	Cable Lines	2002	518		20	52	52	138	19
20	Cable Lines	2002	1,025		20	103	103	273	20
21	Chiller	2002	890		20	89	89	237	21
22	Dining Room Renov	2002	17,195		20	1,720	1,720	4,299	22
23	Leasehold Imrprovement	2002	689		20	69	69	155	23
24	Leasehold Improvements	2002	954		20	95	95	207	24
25	Leasehold Improvements	2002	1,910		20	191	191	414	25
26	Pump Motor	2002	1,100		20	110	110	229	26
27	Water Treatment System	2002	1,004		20	100	100	243	27
28	Window Treatments	2002	650		20	65	65	168	28
29	Locks	2002	508		20	51	51	152	29
30	Chiller	2002	8,760		20	876	876	1,971	30
31	Carpeting	2003	527		20	75	75	151	31
32	Lighting And Ballists	2003	548		20	27	27	55	32
33	Covers	2003	750		20	75	75	144	33
34	TOTAL (lines 1 thru 33)		$ 11,967,083	$ 296,158		$ 348,596	$ 52,438	$ 2,214,155	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 11,967,083	$ 296,158		$ 348,596	$ 52,438	$ 2,214,155	1
2	Applied Sealcoating	2003	1,145		20	115	115	172	2
3	Carpeting For 14 Rooms	2003	24,080		20	3,440	3,440	4,873	3
4	Generator Service	2003	1,150		20	58	58	72	4
5	Door Keypads	2003	1,288		20	64	64	81	5
6	Front And Back Door Keypads	2003	958		20	48	48	60	6
7	Corner Guards	2003	1,788		20	179	179	209	7
8	Elevator Repair	2003	1,300		20	65	65	76	8
9	Paint	2003	1,652		20	165	165	193	9
10	Pave Lot	2003	1,376		20	138	138	161	10
11	Elevator Repair	2003	813		20	41	41	47	11
12	Wrist Band Trnsm.	2003	1,010		20	202	202	236	12
13	Sprinkler System	2003	581		20	58	58	82	13
14	Repair Dietary Door	2004	1,100		20	183	183	183	14
15	Pop Up Spray Heads	2004	654		20	55	55	55	15
16	Damper Motor	2004	1,635		20	245	245	245	16
17	New Damper	2004	1,763		20	264	264	264	17
18	Fire Alarm Repair	2004	1,009		20	151	151	151	18
19	Fire Damper Repair	2004	1,631		20	245	245	245	19
20	Door Delay Lock	2004	2,247		20	150	150	150	20
21	Nustep	2004	3,530		20	206	206	206	21
22	Door Opener	2004	2,040		20	238	238	238	22
23	Wiring	2004	695		20	35	35	35	23
24	T-Stat	2004	1,050		20	53	53	53	24
25	Paint Job	2004	3,550		20	118	118	118	25
26	Lawn Cleanup	2004	7,000		20	233	233	233	26
27	Carpet Strips	2004	1,359		20	45	45	45	27
28	Repair Booster Heater	2004	1,052		20	35	35	35	28
29	Generator Service	2004	601		20	40	40	40	29
30	New Camera System	2004	7,002		20	175	175	175	30
31	Replace Spray Heads	2004	520		20	13	13	13	31
32	Security Power Supply	2004	540		20	27	27	27	32
33	Generator Maint	2004	1,293		20	65	65	65	33
34	TOTAL (lines 1 thru 33)		$ 12,044,495	$ 296,158		$ 355,745	$ 59,587	$ 2,222,993	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 12,044,495	$ 296,158		$ 355,745	$ 59,587	$ 2,222,993	1
2	Wrist Band Transm	2004	999		20	50	50	50	2
3	4 Mag Locks	2004	3,692		20	62	62	62	3
4	Lab & Wiring 2Nd Fl	2004	595		20	20	20	20	4
5	Lab & Wiring Sys Buzzing	2004	760		20	25	25	25	5
6	Elevator Hatch Doors	2004	2,651		20	530	530	530	6
7	Pump Drain	2004	1,667		20	28	28	28	7
8	Floor Treatment	2004	810		20	17	17	17	8
9	Paint	2004	2,330		20	97	97	97	9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
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19									19
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 12,057,999	$ 296,158		$ 356,574	$ 60,416	$ 2,223,822	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 12,057,999	$ 296,158		$ 356,574	$ 60,416	$ 2,223,822	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 12,057,999	$ 296,158		$ 356,574	$ 60,416	$ 2,223,822	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 12,057,999	$ 296,158		$ 356,574	$ 60,416	$ 2,223,822	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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22									22
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 12,057,999	$ 296,158		$ 356,574	$ 60,416	$ 2,223,822	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 12,057,999	$ 296,158		$ 356,574	$ 60,416	$ 2,223,822	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 12,057,999	$ 296,158		$ 356,574	$ 60,416	$ 2,223,822	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 12,057,999	$ 296,158		$ 356,574	$ 60,416	$ 2,223,822	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 12,057,999	$ 296,158		$ 356,574	$ 60,416	$ 2,223,822	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 12,057,999	$ 296,158		$ 356,574	$ 60,416	$ 2,223,822	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 12,057,999	$ 296,158		$ 356,574	$ 60,416	$ 2,223,822	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 12,057,999	$ 296,158		$ 356,574	$ 60,416	$ 2,223,822	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 12,057,999	$ 296,158		$ 356,574	$ 60,416	$ 2,223,822	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		$ 12,057,999	$ 296,158		$ 356,574	$ 60,416	$ 2,223,822	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 12,057,999	$ 296,158		$ 356,574	$ 60,416	$ 2,223,822	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	240		1998	1998	$ 11,715,725	$ 260,958	35	$ 334,735	$ 73,777	$ 2,165,123	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Fence - South Shore Building Company			1998	10,094		20	505	505	3,030	9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
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35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
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61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 11,725,819	$ 260,958		$ 335,240	$ 74,282	$ 2,168,153	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	2201 Main LLC			2002	$ 25,654	$ 641	40	$ 641	$	$ 1,603	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Allocation - 2201 Main LLC			2002	21,193	1,060	20	1,060		2,649	9
10	Allocation - 2201 Main LLC			2003	24,975	1,249	20	1,249		1,873	10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
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29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 71,822	$ 2,950		$ 2,950	$	$ 6,125	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,173,027	$ 64,192	$ 126,273	$ 62,081	10	$ 795,887	71
72	Current Year Purchases	134,880	28,208	30,449	2,241	10	30,449	72
73	Fully Depreciated Assets	3,453				10	3,453	73
74								74
75	TOTALS	$ 1,311,360	$ 92,400	$ 156,722	$ 64,322		$ 829,789	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Alloc from Care Centers		$ 36,707	$ 2,712	$ 2,712	$	5	$ 30,530	76
77										77
78										78
79										79
80	TOTALS			$ 36,707	$ 2,712	$ 2,712	$		$ 30,530	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 13,776,683	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 391,270	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 516,008	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 124,738	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,084,141	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

SEE ACCOUNTANTS' COMPILATION REPORT

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Allocation from Care Centers				6,624			5
6								6
7	TOTAL				$ 6,624 **			7

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 6,285 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	Chevy Malibu	$ 328.73	$ 3,616	17
18					18
19					19
20					20
21	TOTAL		$ 328.73	$ 3,616	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

			1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies					
3	Classroom Wages	(a)				
4	Clinical Wages	(b)				
5	In-House Trainer Wages	(c)				
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS		$	$	$	$
10	SUM OF line 9, col. 1 and 2	(e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 310,239	$		$ 310,239	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			9,054			9,054	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			278,139			278,139	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				222,235		222,235	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental						230,464		230,464	13
14	TOTAL			$		$ 597,432	$ 452,699		$ 1,050,131	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/04 Ending: 12/31/04

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/04 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,464	$ 59,700	1
2	Cash-Patient Deposits	116,616	116,616	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,234,564	3,234,564	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	298,881	298,881	6
7	Other Prepaid Expenses	14,830	14,830	7
8	Accounts Receivable (owners or related parties)	1,163,860		8
9	Other(specify): See Attached Schedule	5,893,504	5,893,504	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 10,723,719	$ 9,618,095	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		352,000	13
14	Buildings, at Historical Cost		10,177,369	14
15	Leasehold Improvements, at Historical Cost	217,887	680,506	15
16	Equipment, at Historical Cost	315,069	2,763,761	16
17	Accumulated Depreciation (book methods)	(259,939)	(4,648,097)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule		66,347	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 273,017	$ 9,391,886	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 10,996,736	$ 19,009,981	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,501,215	$ 1,501,216	26
27	Officer's Accounts Payable		184,480	27
28	Accounts Payable-Patient Deposits	104,705	104,705	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	310,320	310,320	30
31	Accrued Taxes Payable (excluding real estate taxes)	40,163	40,163	31
32	Accrued Real Estate Taxes(Sch.IX-B)	344,335	344,335	32
33	Accrued Interest Payable		59,701	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	35,567	35,567	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,336,305	$ 2,580,487	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		12,428,391	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 12,428,391	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,336,305	$ 15,008,878	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 8,660,431	$ 4,001,103	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 10,996,736	$ 19,009,981	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 7,133,962	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 7,133,962	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,645,469	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(119,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 1,526,469	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 8,660,431	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 11,220,155	1
2	Discounts and Allowances for all Levels	(2,747,596)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,472,559	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,698,120	6
7	Oxygen	44,381	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,742,501	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	234,620	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	79,851	19
20	Radiology and X-Ray	8,240	20
21	Other Medical Services	61,014	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 383,725	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	450,004	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 450,004	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	1,875	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,875	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 12,050,664	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,762,269	31
32	Health Care	3,453,340	32
33	General Administration	2,245,727	33
	B. Capital Expense		
34	Ownership	1,761,968	34
	C. Ancillary Expense		
35	Special Cost Centers	1,050,131	35
36	Provider Participation Fee	131,760	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,405,195	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,645,469	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,645,469	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** not complete **If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** **SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,610	2,264	$ 86,047	$ 38.01	1
2	Assistant Director of Nursing	3,661	4,157	111,929	26.93	2
3	Registered Nurses	13,366	15,186	321,117	21.15	3
4	Licensed Practical Nurses	54,972	59,609	1,156,515	19.40	4
5	Nurse Aides & Orderlies	128,972	137,742	1,211,243	8.79	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,505	8,091	96,370	11.91	8
9	Activity Director	2,024	2,182	32,736	15.00	9
10	Activity Assistants	15,155	16,419	132,220	8.05	10
11	Social Service Workers	12,856	14,003	167,618	11.97	11
12	Dietician					12
13	Food Service Supervisor	3,807	4,127	62,104	15.05	13
14	Head Cook					14
15	Cook Helpers/Assistants	31,412	33,579	268,079	7.98	15
16	Dishwashers					16
17	Maintenance Workers	7,150	7,687	83,370	10.85	17
18	Housekeepers	28,833	30,796	237,011	7.70	18
19	Laundry	13,065	14,174	111,372	7.86	19
20	Administrator	2,022	2,172	54,628	25.15	20
21	Assistant Administrator	1,989	2,124	43,225	20.35	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,339	10,143	100,094	9.87	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,204	2,318	23,262	10.04	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	1,741	2,038	17,858	8.76	33
34	TOTAL (lines 1 - 33)	341,683	368,811	$ 4,316,798 *	$ 11.70	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	254	$ 11,054	01-03	35
36	Medical Director	monthly	9,750	09-03	36
37	Medical Records Consultant	monthly	4,472	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthly	3,651	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	16	952	11-03	44
45	Social Service Consultant	37	2,025	12-03	45
46	Other(specify)				46
47	Psycho-Social Consultant	3	162	12-03	47
48	Care Centers (see attached)		21,824	various	48
49	TOTAL (lines 35 - 48)	310	$ 53,890		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45. ** See instructions.

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
David Vardi	Administrator	0	$ 54,628
Blake Willey	Asst. Admin.	0	43,225
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 97,853

B. Administrative - Other

Description	Amount
Management Fees - Eric Rothner	$ 9,713
Management Fees - Ronald Abrams	12,000
Management Fees - Alan Abrams	12,000
See Supplemetal Schedule	12,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 45,713
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Various - see attached	Legal	$ 12,580
Care Centers Inc.	Legal	21,900
Care Centers Inc.	Accounting	15,000
Frost, Ruttenberg & Rothblatt	Accounting	18,000
Maxxsource	Data Processing	280
Care Centers Inc.	Data Processing	8,640
ADP	Payroll Services	13,923
BDO Seidman	Line of Credit Fees	1,274
Care Centers Inc.	Professional Fees	11,100
Morton Cohen	Pharmacy Cost Management	6,985
SMS	Medicare Consulting	10,744
See Supplemetal Schedule		285,080
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 405,506

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 107,345
Unemployment Compensation Insurance	93,841
FICA Taxes	330,235
Employee Health Insurance	197,445
Employee Meals	7,774
Illinois Municipal Retirement Fund (IMRF)*	
Chicago Employer Tax	20,074
Employee Physicals	1,108
Pension Expense	22,093
Other Employee Welfare	2,009
Holiday Expense	3,828
TOTAL (agree to Schedule V, line 22, col.8)	$ 785,752

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 3,400
Advertising: Employee Recruitment	4,387
Health Care Worker Background Check	
(Indicate # of checks performed 129)	2,602
Dues & Subscriptions	10,967
Licenses & Fees	3,301
Advertising & Promotion	26,964
Allocated from Care Centers	3,672
Less: Public Relations Expense	( )
Non-allowable advertising	(26,964)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 28,329

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,837
Educational Expense	879
Allocated from Care Centers	5,319
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 8,035

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Ctr # 0042119 Report Period Beginning: 01/01/04 Ending: 12/31/04

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **ICLTC - $11,491**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **473** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **131,760**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **7,774** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.